QUALIFICATIONS OF TEXAS TRAUMA CARE PERSONNEL

This section addresses the qualifications and characteristics of trauma care personnel. It is intended to serve as a guide in establishing a facility's trauma program and as a measure for evaluating commitment to trauma patient care.

ORGANIZATION

The Trauma Service

The trauma service is established by the medical staff and is responsible for coordinating the care of injured patients, the training of personnel, and trauma quality management. Privileges for physicians participating on the trauma service will be determined by the medical staff credentialing process. All patients with multiple system or major injury must be evaluated by the trauma service and/or other appropriate surgical service(s). The surgeon responsible for the overall care of the patient must be identified.

The Trauma Service Director

The Trauma Service Director shall be a board certified surgeon (see page 2) with demonstrated special competence in trauma care. Through the quality management process, the director will have oversight authority for all trauma patients and administrative authority for the facility's trauma program. The director, along with the medical staff credentials committee and in consultation with appropriate service chiefs, is responsible for recommending appointment to and removal from the trauma service.

THE TRAUMA TEAM

A team approach is required for the optimal care of patients with multiple system injuries. The respective roles of the personnel on the trauma team must be defined by the director of the trauma service. The specific composition of the trauma team in any facility will depend on the characteristics of that facility and its staff. In deciding on the composition of the trauma team, several general principles should be applied. First, trauma team care should be a coordinated effort, because the multiple, complex problems present in trauma patients require involvement of individuals with expertise in a number of areas. These complex problems, however, frequently occur simultaneously or overlap. Rarely, if ever are they separable into distinct time frames. It is unacceptable for the emergency physician, general surgeon, the anesthesiologist, the orthopedic surgeon, and the medical consultant to each "complete" his or her job and then "pass the patient on" to the next phase. The result may be unnecessary delay, missed injuries, conflicting management, and disability or death when a coordinated approach would have produced a gratifying outcome.

Second, the team leader must be a qualified surgeon who is clinically capable in all aspects of trauma care. This surgeon must not only contribute specific care in the area of his or her specialty, but must also continually oversee and coordinate the operation of the team and the care of its patients throughout their hospital stay. Finally, the team leader must be able to interpret and reconcile the recommendations of team members and consultants from a number of specialties and accept the responsibility for transmitting them to hospital staff.

QUALIFICATIONS OF THE TRAUMA SERVICE DIRECTOR

The director of the trauma service will meet all of the specific qualifications for surgeons (see page 3), including board certification, personal involvement in care of the injured, education in trauma care, and involvement in professional trauma organizations.

Additional qualifications and activities of the director should include the following:

1. EDUCATIONAL ACTIVITIES

Educational activities of the trauma director should include participation as an instructor in the American College of Surgeons' Advanced Trauma Life Support (ATLS) or equivalent course, participation in other continuing medical education (CME) courses, and provision of instruction to other health care personnel. Active involvement in several such activities is expected of trauma service directors at Comprehensive and Major facilities.

Training and educational programs within a department of surgery that are specifically designed to prepare surgeons for delivering a high level of treatment of trauma patients are required of Comprehensive facilities.

Service directors at all trauma facilities have the specific responsibility for the evaluation of newly appointed members of the trauma service and overseeing ongoing education for new and existing attendings, as appropriate.

2. COMMUNITY/NATIONAL INVOLVEMENT IN TRAUMA CARE SYSTEMS

The participation of a facility's trauma director (or designee) in the development of trauma systems at community, regional, state, or national levels is expected in all Comprehensive and Major facilities.

3. RESEARCH, PUBLICATIONS, AND PRESENTATIONS IN TRAUMA-RELATED AREAS

Clinical and basic research with the publication of results are natural outgrowths of a strong, sustained interest in trauma. Stimulation of such activities is the responsibility of the trauma service directors since they are essential hallmarks of the Comprehensive Trauma Facility. Presentations at appropriate forums are expected from the trauma leaders at hospitals of all levels.

SPECIFIC QUALIFICATIONS FOR SURGEONS

1. BOARD CERTIFICATION

Basic to qualification for trauma care for any surgeon is board certification in a surgical specialty recognized by the American Board of Medical Specialties and/or the American Board of Osteopathic Specialties. It is acknowledged that many boards require a practice period, and that complete certification may take three to five years after an Accreditation Council for Graduate Medical Education (ACGME) or Committee on Post-Doctoral Training of the American Osteopathic Association (CPDTAOA) approved residency. If an individual has not been certified five years after the successful completion of a ACGME or CPDTAOA residency, that individual is ordinarily unacceptable for inclusion on the trauma team. Such an individual may be included when recognition by major professional organizations has been received in his or her specialty (e.g., American College of Surgeons, American Osteopathic Association).

2. CLINICAL INVOLVEMENT

Qualified surgeons must be regularly involved in the care of injured patients. In a hospital committed to trauma care, surgeons with special expertise in trauma should be identified. In Comprehensive and Major facilities, surgeons with primary patient care responsibilities should participate in the care of approximately 50 or more patients with immediately life-threatening and/or urgent injuries per year. Participation in the organization of trauma protocols, trauma teams, trauma call rosters, and trauma rounds are clear indicators of commitment to excellence in trauma patient care.

3. EDUCATION

The background of trauma surgeons should reflect an interest in and a commitment to trauma care. Formal trauma fellowships, training in surgery on an active trauma service, or combat experience as a surgeon constitute prime examples of such interest.

All members of the trauma team should be involved in at least 16 hours of trauma-related CME annually. Active participation as an instructor for the ATLS or equivalent course clearly demonstrates educational involvement in trauma and is encouraged.

4. REGIONAL/NATIONAL COMMITMENT

The major trauma organizations in the United States at present include 1) the Committee on Trauma of the American College of Surgeons and its state committees; 2) the American Association for the Surgery of Trauma; 3) the American Burn Association; and 4) trauma organizations of various surgical specialties, such as the Orthopedic Trauma Association and the Joint Section on Neuro-Trauma and Critical Care of the American Association of Neurological Surgeons. The criteria governing membership in these organizations are such that active membership ordinarily signifies a position of leadership among trauma surgeons. Participation in regional groups, such as state and regional trauma committees, and membership in regional organizations identify significant involvement in and commitment to trauma related matters.

SPECIFIC QUALIFICATIONS FOR NONSURGICAL SPECIALISTS

EMERGENCY PHYSICIANS

Many physicians participate in the care of the severely injured patient in the emergency department. In most Comprehensive and many Major facilities, the initial evaluation and resuscitation are led by experienced in-hospital surgical staff. In other institutions, the initial evaluation and resuscitation are performed by an emergency physician. That physician must be a member of the trauma team who participates in the care of the patient and in all of the audits and critiques necessary for excellence in trauma care. Board certification in an appropriate medical specialty is essential, as is additional specific preparation for care of the injured patient. An example of such preparation is the successful completion of the ATLS or equivalent course.

Emergency physicians should be involved with surgeons in the development of trauma care systems as part of the overall development of emergency medical systems in a community, state, province, or region. In addition, they should be active in organizations contributing to the benefit of injured patients.

ANESTHESIOLOGISTS

The crucial role of the anesthesiologist in the management of the multiply injured patient is obvious. In addition to responsibilities in the operating room, personnel from the anesthesia care team may, under the aegis of the trauma team, play an important role in preoperative airway control and resuscitation and as a postoperative consultant in cardiorespiratory support and pain control. Anesthesiologists who participate on the trauma team should 1) be appropriately certified, 2) have the necessary educational background, and 3) engage in trauma quality management and in investigative, teaching, and community activities analogous to those of the surgeons.

MEDICAL CONSULTANTS

Medical specialists including cardiologists, pulmonary medicine specialists, nephrologists, and their respective support teams (e.g., respiratory therapy and dialysis teams) provide specific expertise as planning resources and for consultation. However, the surgeon should not relinquish the overall responsibility for trauma patient care. In addition to appropriate board certification, such medical consultants should have an awareness of the unique problems of trauma patients.

NURSES

Nursing personnel occupy a crucial position in the care of the injured, both in the prehospital and hospital phases of treatment. This position is exemplified by the role of the trauma nurse coordinator who shall be a registered nurse. However, specific commitment to care of injured patients can be demonstrated in several ways.

Nurses who participate in the prehospital phase are highly trained for this function. They work within well-developed advanced life-support systems that include specialized teams for prehospital care and long-range transport systems involving both fixed-wing or rotorblade aircraft.

In the facility committed to trauma care, the emergency department nursing staff will provide a high level of dedication and skill in the care of injured patients. Integration of nurses into the trauma team or service should have a high priority. Involvement of nurses in trauma training and research is also important.

PRE-HOSPITAL EMERGENCY MEDICAL CARE PERSONNEL

Personnel providing pre-hospital emergency medical care must be certified by the Texas Department of Health. Those personnel who function at the Advanced Life Support level must have a physician medical director and provide care through written standing orders, on-line medical control, or a combination of both. Pre-hospital emergency medical care personnel may participate in trauma care in either the pre-hospital or hospital phases of trauma care.

Pre-hospital care providers, whether functioning at the Basic or Advanced Life Support level, typically are the first care providers for the trauma patient, and as such, are considered an essential component of a trauma care system.

PHYSICIAN ASSISTANTS

Physician assistants may be incorporated into specialized teams engaged in trauma care. Their specific involvement will be determined by hospital policy and the trauma director.

TRAUMA
2/28/91